FREQUENTLY ASKED QUESTIONS

MDCH "PIHP/ENCOUNTER REPORTING HCPCS and REVENUE CODES"

Volume 1, October 10, 2003

Notes:

1. A joint Department of Community Health and Michigan Association of Community Mental Health Boards group called Encounter Data Integrity Team (EDIT) reviews the requests for new codes to be added to the code list. It has established a number of principles to guide decisions about additions to the code list, including containing the number of codes used for any one service, and to the extent possible, using codes for a service that have the same unit type.
2. The modifier HK must be used with all habilitation supports waiver codes. It must not be used for state plan or alternative services that a habilitation supports waiver beneficiary receives.
3. Use of the term "waiver" in the CMS description of codes is not synonymous with Michigan's habilitation supports waiver or children's waiver.

General questions about services

1) State Plan is synonymous with "Medicaid Covered Service"?

The term "Medicaid covered" service is frequently used to describe both state plan and 1915(c) waiver services.

2) Local Boards are required to provide the State Plan services?

PIHPs are required to provide state plan services, habilitation waiver services, and to make available alternative services to Medicaid beneficiaries.

Alternative services

3) Services identified as "Alternative Services", are synonymous with "Medicaid Covered Service" but are optionally available as determined by the PIHP?

No, alternative services are not covered services, however Medicaid funds can be used to pay for them, and the PIHP needs to make them available to Medicaid beneficiaries.

4) "Alternative Services" funding is available for both mental health and DD consumers except when otherwise noted?

They are available to Medicaid beneficiaries with either mental illness or developmental disabilities except when otherwise noted.

5) In the category "Housing Assistance", the Reporting Code Description includes the clauses, "waiver, per service" while the Coverage indicates "Alternative Services. This seems inconsistent. Also, since it indicates both "per service" and a Reporting Unit of "Month", does this mean we should expect to receive a claim of one encounter per service but report this as one month summary of all encounter claims? This seems inconsistent and contrary to previous statements indicating an expectation of "sending what we receive".

Codes whose descriptions include the term "waiver" can be used for reporting alternatives that were delivered where permitted by DCH/PIHP contract. Report a sum of services delivered in a month.

6) Should we report PATH and Shelter Plus under Housing Assistance?

No, report PATH and Shelter Plus in the Sub-Element Cost Report at the end of the year. The report format will be revised to accommodate it.

7) Is Z9071 (CLS Staff for MI consumers), now H2015, and the population being served is for HAB DD consumer, and an alternative service for the mental health population?

HSW beneficiaries, and beneficiaries with either DD and MI are eligible for community living supports.

8) Family training is not listed on the crosswalk as DD only, however, it is not in Section 6.5.1.1 as an alternative for MI persons. Can this code be used for persons with MI?

The code called Family training may be used for either alternative service called Family Skills Development (MI) or Family Skills Development/Training (DD). See the MDCH/PIHP contract, Section 2.1.1, page 24.

9) Is it OK to use T codes developed by CMS for waiver services to report alternative services?

Yes, it is okay.

<u>Assessments</u>

10) What is the definition of T2010 and T2011?

T2010 is Preadmission Screening and Resident Review (PASRR) Level I Identification Screening, per screen

T2011 is Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per evaluation.

11) Is the assessment/functional assessment part of a bundled service in Assistance with Challenging Behaviors or does it need to be reported separately under the other code of Assessment and Other Testing?

The assessment and testing completed by a psychologist is considered an Assessment for encounter reporting and would use one of the HCPCS codes under psychological testing.

12) Do we report intake, referral and initial screens that we do at screening centers as assessments?

If these activities are performed by a clinician face-to-face with the beneficiary you can report them as assessments; if the activities are performed over the telephone or by a staff person who is not a clinician, then they are administrative functions.

13) We understand the coding of Home Based services to be H0036, but are not clear if that code also includes assessments, treatment planning, reviews etc that the home-based worker does. Would all these other services done under home-based also be coded H0036, or do they all still get reported under their own separate code – T1001 for assessment, H0032 for treatment planning, etc?

Use the code H0036 for all the activities of the home-based workers. If other professionals who are not part of the home-based team perform assessments then report those services using the relevant codes.

14) Code "97802" and "97803" are listed in both "Assessments" and "Health Services". Is this intentional?

Yes

15) Can LPNs do assessments?

No. See page 12 of the revised Chapter III, section 3.2 Assessments; and definition of "Health care professional" on page 5, section 1.6 Definition of Terms.

16) What code do we use to report administration of the CAFAS functional assessment?

We would expect CAFAS to be performed as part of an otherwise reportable assessment encounter. The CAFAS itself is not a reportable encounter.

Day Program "Settings"

17) Coverage was not listed for Day Program, S5100 and S5102. If this is an oversight, what is the coverage? If not an oversight, is the coverage yet undetermined, in whole or in part? If undetermined in part, what coverage is already determined and what undetermined?

Day program is not a coverage but rather a site where Medicaid state plan, waiver, or alternative services may be provided. For the '03-04 FY, time spent at a day program site may be reported in 15-minute units. The next year ('04-05), PIHPs will have to report the services that are provided at a day program site. The code S5102 is not to be used in the encounter data reporting.

Crisis Interventions and Crisis Stabilization and Response

18) The code S9484 assigned to Crisis Interventions has a unit of one hour. Most our interventions are for less than an hour. How are we to report that activity?

The code list has been revised: the code S9484 with one hour unit has been assigned to the state plan service called Intensive Crisis Stabilization. The code H2011 with a 15-minute unit has been assigned to the state plan service called Crisis Intervention. The alternative service for persons with developmental disabilities called Crisis Stabilization and Response will use the H2011 code with a modifier HE in the first position following the HCPCS code.

Habilitation Supports Waiver Services

19) Coverage for "Out of Home Non Vocational Habilitation" and "Out of Home Prevocational Service", is strictly limited to Habilitation Supports Waiver consumers, correct?

Yes. However, the alternative service called Skill-building Assistance (H2014) includes out-of-home adaptive skills training, rehabilitative services, and pre-vocational services. See pages 23 and 26 of the MDCH/PIHP contract Attachment P.6.5.1.1.

20) Enhanced Pharmacy", we are directed to "identify product in "remarks". Could you clarify precisely where in the 837P, you are specifying this, loop, segment etc.?

Loop 2300 NTE01 would be reported with the value of "ADD" and Loop 2300 NTE02 would contain the code(s) and products, for example "T1999 product name".

21) In "Enhanced Medical Equipment & Supplies", no specific listing is shown for "ADL Aids" former code Z9171. What code is this now? *S5199*
Should Z9166 now be considered an E1399? *No, T2029*
Should Z9168 now be considered T1999? *No, T2028*

22) If the HSW coverage of supported employment (H2023) is for 10 hours or more of service, how do we report when a beneficiary receives less than 10 hours? How do we report if a HSW beneficiary works with on-going supports, such as a job coach, that are 50% or more of the employment hours?

If a HSW beneficiary receives less than 10 hours of supported employment or receives ongoing supports for 50% or more of the time in supported employment, you will need to report it as the alternative service called skill-building assistance (H2014)

Inpatient Psychiatric Hospital Reporting

23) In "Inpatient Psychiatric Hospital Admissions", Revenue Code "0144" is missing; it does turn up mysteriously on page 9, as a Revenue Code for ancillary services.

You are to report the number of days the individual spent in an inpatient unit using code 0100 regardless of how the claim comes to you.

24) Can Extended Observation Beds (Rev. 0762) be used for services provided in a non-hospital setting? What about using it for time spent in crisis residential where the individual left before midnight?

No. This revenue code is for outpatient hospital extended observation and cannot be used to identify other settings. The NUBC manual describes this as "Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests."

If an individual leaves a crisis residential program before midnight, you cannot report that day.

Medication Administration

25) In "Medication Administration", should we consider HCPCS code 90788 as a one-to-one replacement for Z9046? Why is code H0033 not included?

90788 is for injections of antibiotic – it is not a direct replacement for Z9046. You will need to use the code from the three listed that best meets the description of the service you provided. H0033 will be used in the Substance Abuse Program for reporting administration of LAAM.

26) Previously we had a category of "Injectable Psychotropic Drugs" with "J" codes. These are no longer listed. Why?

These codes are not reported on an encounter basis, rather they are billed fee-for-service to DCH.

27) After reviewing the codes given in "Medication Administration", no code listed in for orally administered medication, they are all listed under the "Injections" section of the CPT manual. Is there a correct code for orally administered medication? Why is code H0033 (Oral medication administration, direct observation) not included?

Medication administration is covered under health services, T1002-RN services up to 15 min. Medication administration supervision (or observation) would be covered under personal care in a specialized residential setting (T1020), or community living supports (H2015) in own/family home (HSW or alternative service)

28) Client comes in for a med review, sees a nurse for blood pressure, temperature, etc, then goes in and see the doctor who has a different nurse present with the doctor, then comes out and another nurse organizes the med prescription, passes on samples, explains the med to the client, etc. What three separate HCPCS/CPTs would we use to code the nursing contacts?

Procedure code 90862 for medication reviews encompasses all of the support services you have described. There is no separate reporting for each individual nurse performing a part of the total medication review.

29) Can LPNs give injections?

No

Medication Review

30) If a medication review is done and an AIMS test is a part of that medication review, it appears that it would be reported as one encounter or might it be two encounters if the med review is done by the doctor and the nurse does the AIMS test during the same scheduled appointment?

Report one encounter for med review.

Specialized residential reporting

31) The first crosswalk for FY'03 says that the S5140 should be reported on the institutional claim format. The new crosswalk says it should be reported on the professional format. My system is already set up to do the former; do I have to convert everything for FY'03?

Specialized Residential (S5140), Supported Independent Housing (H0043), and Crisis Residential ((H0018) can be submitted on the institutional format for FY'03 services but you must report on the professional format for any of those services that are delivered after 10/1/03. Conversely you may submit FY'03 (back to 10/1/02) data for those services on the professional format.

32) In Specialized Residential, is it correct to assume that the parenthetical expression and the note, apply both to adults and children? Also, the coverage is not listed, therefore, if this is an oversight, what is the coverage? If not an oversight, is the coverage yet undetermined, in whole or in part? If undetermined in part, what coverage is already determined and what undetermined?

Yes, specialized residential applies to both adults and children. Like a day program site, this in not a Medicaid service, this is a site where Medicaid services are delivered. Next fiscal year ('04-05) you will need to unbundle the Medicaid services provided in specialized residential settings and report them separately.

Targeted Case Management and Supports Coordination

33) Supports Coordination does not specify "Face-to-face" while Targeted Case Management does specify "Face-to-face." Are we allowed to report activity that is not Face-to-Face with the consumers as Supports Coordination?

Report only face-to-face contacts for supports coordination.

34) What are the differences between targeted case management and supports coordination (HSW or alternative for DD)?

The focus of activities is basically the same. The major differences are that you must determine and document the need for case management initially and an ongoing basis; and the provider qualifications for care managers are more rigorous than for supports coordinator (see Chapter III, section 13.1, and section 15.2.A.)

35) H0032 is not being used by case managers or supports coordinators, correct? Do you expect to see all services performed by case managers and supports coordinators as T1017 and T1016 respectively?

Yes, use T1017 for all face-to-face contacts between case manager and beneficiary, and T1016 for all face-to-face contacts between supports coordinator and beneficiary.

36) Is H0032 to be used for Home Based or do you expect all services in that program to be H0036?

Home-based activity including case management should be reported as H0036.

37) Case management and supports coordination may not be provided to residents in a nursing home, yet the code for Nursing Facility Mental Health Monitoring is the same as targeted case management. Won't this cause a problem.

No, we will be able to determine that the service was provided in a nursing home and that its purpose was to monitor the mental health services provided there.

38) Can we report the time spent by the supports coordinator in supervising the supports coordinator assistant?

Report only the face-to-face contacts made between the supports coordinator assistant and the beneficiary.

<u>Treatment Planning</u>

39) Person-centered planning seems to have been divided into two groups but we are uncertain if Z9154 was intended for the MI population and Z9157 for the DD or if either code could be used for either population, with the difference being that Z9157 was more of an initial, major planning and Z9154 being for subsequent reviews of plans. Can you make that distinction for us? We believe that in any event, these are all supplanted by H0032.

Yes, H0032 covers both populations.

40) From the code list it appears that H0032 includes both the development and the review of the [treatment] plan. Is it true that there are no longer two separate codes such as Z9154 for the review and Z9157 for the development of the plan?

Use H0032 for both development and review of an individual plan of service that is done by professional staff chosen by the consumer, and/or outside facilitators face-to-face with the consumer during person-centered planning. Case managers and supports coordinators should report their time in face-to-face treatment planning as part of Targeted Case Management (T1017) or Supports Coordination (T1016). See page 59 of Chapter III, Section 3.24 Treatment Planning.

41) Is the "annual" treatment plan date being eliminated and replaced by whatever data the consumer selects to revisit/re-do the Person Centered Plan?

The individual plan of service should be reviewed at least annually during person-centered planning, or sooner if the consumer requests it or a change in his/her situation demands it.

Use of Modifiers

Note: the revision of the code list includes two modifiers for specialized residential setting reporting (S5140 and S5145). The modifiers are used to distinguish levels of specialized residential costs: no modifier is used when the value is less than $65 per day for basic care; TF for a value of $64-124 per day for intermediate care; and TG for a value of $125 or more per day for complex care.

41) Modifiers TD and TE were in use in a number of reporting categories, have these been eliminated from all but Respite Care?

Yes

42) Also, we're using modifiers AJ, AH, HO, HP to identify "who", clinically provided certain services. Any problem with this?

Not a problem. Just make sure that you add any local modifiers after MDCH-required modifiers (e.g., HK for Habilitation Supports Waiver, and HE for the alternative crisis stabilization and response) which should be placed in the first position after the HCPCS code.

43) I see modifier TT for Private Duty Nursing. Is it OK that we use that modifier for other services too?

Yes, you can use that modifier for other services.

44) Can we use the modifier HK for all services that were provided to a Habilitation Supports Waiver beneficiary, not just those that are HSW services?

No, you must use the modifier HK for only the HSW services an HSW beneficiary receives.

New Code Requests: Note: Any valid CPT/HCPCS code can be used for local tracking and reporting, and it would not be rejected by the state. However, EDIT has agreed to the set of codes on the code list. So, if you use additional CPT/HCPCS codes locally, kindly translate those additional codes to the codes on the code list prior to submitting encounter data to the state.

45) Codes T2040 and T2041, seem to be appropriate for some of our consumers, when fiscal intermediaries are involved, can we use either? If neither, why not?

Per the EDIT a decision was made not to break out the FI separately. This would be counted as an indirect cost.

46) We could like to be able to use H2025, "Ongoing Support to Maintain Employment, per 15 min." for long-term supported employment. Can this be added?

No, EDIT determined that we do not need an additional code for supported employment. H2023 covers the supported employment activities that should be reported to MDCH

47) We were given a code for H0045 for Respite care service, not in home, per diem, which suits some of our service needs perfectly. Can you add this to the Encounter Reporting Codes listing?

EDIT agreed to use two codes: T1005 respite care, up to 15 minutes; and S5150 Respite care by unskilled person.

48) I need a code for oral interpreter so I found T1013, but it is not on the list.

The cost of oral interpreters should be included as part of indirect costs and not reported separately.

49) I also need a HCPCS code for vacant bed days/leave of absence for specialized residential.

Encounter data reporting refers to the service that an individual received on a particular day. This report does not count days of service that an individual did not receive.

50) Could we please have T1003 LPN/LVN services, up to 15 minutes in the Health Services crosswalk?

Health Services requires a registered nurse, nurse practitioner, or dietitian as provider. Therefore, we are not using the code for LPN.

51) In "Occupational Therapy" and "Physical Therapy", codes "97504, and 97520" are not listed, should they be included? *These are health plan codes and so are not listed for PIHPs.* Since these services share the same codes, how will you tell them apart?

We won't be able to tell OT and PT apart in the encounter data.

<u>Clarification Regarding "Optional" Reporting</u>

52) Peer Directed and Operated Services: The crosswalk now indicates "optional to report encounters." Does this mean that it is optional to report Peer Directed Services in the Encounter report, or does it mean that "Encounters" can be used as the Reporting Unit (as opposed to 15 minutes)?

It means that it is optional to report Peer Directed Services on the Encounter report because the nature of the service is such that you may not have an accurate record of whether the individual actually participated in it. You must report the estimate of the participants and the cost in the Sub-element Cost Report.

53) The revised crosswalk now indicates "Optional to report separate encounters." Does this mean that it is optional to report Transportation as a separate service in the Encounter report, or does it mean that "Encounters" can be used as the Reporting Unit?

It is optional to report transportation as a separate service in the Encounter report. Transportation services may be included as part of other services such as day program or PSR, or supported employment and community living supports for habilitation supports waiver beneficiaries or beneficiaries using those services as alternative services.